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The Effectiveness of Faith-Based Organizations for the Prevention of HIV/AIDS In Minorities

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Introduction

Changes in the racial and ethnic composition of the population have important consequences for the Nation's health because many measures of disease and disability differ significantly by race and ethnicity (Health, U.S., 2004). In recent decades the percentage of the population of Hispanic origin, Asian, and Pacific Islander races has risen. The U.S. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic has expanded to dramatically affect African Americans (AA) and Hispanic/Latino communities. While African Americans face the greatest HIV/AIDS burden in the U.S., accounting for an estimated 55 percent of new infections, the toll of the epidemic among Hispanics cannot be ignored (The Body, Complete HIV/AIDS Resource). Both communities face health crises that threaten their future health and human potential. While the increase of new HIV/AIDS cases for Asian/Pacific Islanders are dramatically lower, there is still a need to monitor these communities because of the growing U.S. populations. Native American Indians were not omitted as part of the minority group, but were excluded based on the overall relative percentage of reported HIV/AIDS cases in the U.S. For this reason, along with the combination of socioeconomic, racial, and ethnic disparities of Human Immunodeficiency Virus and Acquired Immunodeficiency Disease Syndrome (HIV/AIDS) in minorities sets the foundation for my research.

The purpose of this study will examine the effectiveness of faith-based organizations (FBOs) for the prevention of HIV/AIDS in minorities. The research will seek answers to the following questions:

1. What behavior change communication strategies have FBOs used to reduce the risk of HIV/AIDS transmission?

2. What is FBO's involvement in helping to mitigate the impact of HIV/AIDS through the help of medical and community liaisons?

3. Can FBOs provide predictable and measurable health benefits in the communities in which they serve?

4. What is the perceived accountability of FBOs for criteria-based and empirical assessments for program effectiveness?

5. Are FBOs making an effective impact and contribution to the formation of HIV/AIDS public policies?

The study did not examine program participants' perspective of faith-based programs because of the time constraint of the study, confidentiality, and the anonymity name-based reporting of states by those affected by HIV/AIDS. There were also study limitations due to FBOs' standards for measuring program outcomes on existing, new, or newly funded programs.

The research methodology included primary and secondary data. Data was compiled from state and governmental agencies, articles, and journals that provided information on FBO's structure, activities, and outcomes. The analysis evaluated programs' descriptions, eligibility, funding, success, and reporting methods. Questionnaires were sent via email to faith-based and community-based program contacts that serviced HIV/AIDS prevention activities. The questionnaire consisted of open-ended questions that addressed the programs' structure and success measures. A second questionnaire of open-ended questions was sent via email to health professionals (e.g., physicians, professors) that use FBOs as a part of an extended service for their clients. Phone contacts were made in an attempt to acquire phone interviews with

HIV/AIDS support- program contacts (e.g., directors, coordinators, educators). Because few surveys were found that explored FBOs' participation in HIV/AIDS activities, programs, or collaborations and few published studies have evaluated the health-service related work of FBOs, the second questionnaire with health professionals was performed to create a balanced, but not totally objective perspective.

To understand the foundation from which FBOs come, it must be defined. Faith-based services that connect with America's social service are explored through the theories upon which they were built. The Roundtable on Religion and Social Welfare Policy defines as FBOs typically having some type of religious affiliation that contain sounds and symbols of faith, which a great deal of time resonates from within the community. FBOs can be congregation-based, independent religious nonprofit, large national faith-affiliated social service providers, and coalition intermediaries that extend into community-based organizations (CBOs) or programs.

Literature Review

A systematic qualitative review of health related databases were conducted. A collection of articles, books, and journals were examined based on their relevance to HIV/AIDS, faith, health promotion, and other related terms. A comprehensive search strategy using health related indexes (e.g., faith-based, community-based, congregations, church, synagogues) were used to describe health service deliveries. Formal reviews of relevant articles were used to determine if FBOs were linked to specific health benefits (e.g., awareness, prevention, intervention, maintenance). Health programs' objectives, locations (e.g., state, region), scope (e.g., community, state, region), target population (e.g., race, ethnicity), and outcomes were overall foci of the literature. Programs were categorized by its design to increase awareness of disease,

risk reduction and prevention, treatment and maintenance goals, or a combination of one or more methods of activity.

The National Institute of Health, the Office of Health Disparities, and the Division of HIV/AIDS Prevention of the Centers for Disease Control provided a wealth of statistical data on the prevalence and incidence rates and the number of ethnic/race reported HIV/AIDS cases related to this research. The National Institute of Health provided numerous articles on prevention messages designed and presented through mainstream media. This information invited other methods on understanding how communication can best facilitate HIV/AIDS efforts.

Various literature provided information on federal programs and initiatives, faith-based, community-based, and minority-based programs that demonstrated initiatives or activities that addressed the HIV/AIDS epidemic in minorities and their communities. The available literature particularly on FBOs, largely descriptive and anecdotal and lacked the ability to empirically test programs' effectiveness. By weaving the components of the literature review and questionnaires, the analysis aimed to provide a more in-depth understanding on methods that aim to improve the HIV/AIDS health status of minorities through health promotion and educational activities.

Background

Racial and ethnic HIV/AIDS concerns. Rapid increases in HIV/AIDS infections are showing up specifically in African American (AA) and Hispanic communities. The Office of Health Disparities and the Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention (CDC) reported during June 1981 and June 1982, 37 percent of more than 400 AIDS reported cases to the CDC were in minority races and ethnicities. In 1990, African Americans

accounted for 30 percent of AIDS cases and Hispanics about 17 percent. Infection rates also continue to escalate for the Asian/Pacific Islander communities. In 1994, the CDC reported 577 new cases. By 2003, 72 percent of the estimated 43,171 cases of AIDS diagnosed in the U.S. were in minority races and ethnicities. While statistics by various reporting agencies differ slightly, the underlying reality of the disproportionate impact of HIV/AIDS infection on racial and ethnic minorities cannot be disputed. The CDC's report of cumulative effects of HIV/AIDS through 2000 were:

- Although Hispanics make up only about 14 percent of the population of the U.S. and Puerto Rico, they account for 18 percent, almost 164,000, of the more than 886,5000 AIDS cases diagnosed since the beginning of the epidemic. By the end of 2002, nearly 88,000 Hispanics died with AIDS.
- Among people given a diagnosis of AIDS since 1994, a smaller proportion of Hispanics (61%), compared with whites (64%) and Asian/Pacific Islanders (69%), were alive after nine years. However, the proportion of surviving Hispanics was larger than the proportions of surviving American Indians and Alaska Native (58%) and African Americans (55%).

AIDS cases reported by the CDC in the U.S. among racial and ethnic minorities from 1985-2003 were reported as follows:

- As a result of the expansion of the AIDS case definition, 30,754 AIDS cases were diagnosed among racial and ethnic groups.

Data reported by Kaiser State Health for the distribution of reported cumulative AIDS cases by race and ethnicity through 2004 are as follows:

- In the U.S., 39.9% are Black (African American).
- In the U.S., 18.7% are Hispanic.
- In the U.S., 0.8% is Asian/Pacific Islander.
- Compared to Caucasians, the rate for cumulative cases is 40.1%.

Racial and ethnic health disparities. The existence of racial and ethnic disparities in health care represents a critical flaw in the U.S. health care system. The system fails to provide equal, high quality health care to all individuals regardless of ethnicity, race, and other factors (American Medical Student Association, 2005). *Healthy People (2000)* facilitated a goal for the elimination of all health disparities in the U.S. and developed a comprehensive strategy of research, education, policy changes, and community partnerships as a key to help in the task. As the U.S. becomes increasingly diverse, physicians are challenged to meet the demands of how and why health disparities exist. The underlying causes for the disparities are related to health care access, resources treatment, outcomes, health status for racial and ethnic minorities, patient-physician relationship, functionality of the health care system, language barriers, cultural barriers and beliefs, provider biases, and stereotyping. Below are some compelling issues and concerns from the American Medical Student Association (AMSA):

AMSA National Initiative on Disparities - Global AIDS

The global HIV/AIDS pandemic is the cause of the greatest health disparities in the world to date. The voice of health professionals is crucial to building a dedicated response to rid the world of AIDS...

AMSA Foundation American Health Care System Survey 2002

In order to help direct medical education reforms that would enable medical schools to better address issues of health policy and disparities in health access, Jeff Huebner, M.D., AMSA's first Jack Rutledge Fellow, and the AMSA Foundation developed the first nationwide, randomized study of medical students' knowledge and attitudes about health policy, health care delivery, options for health care reform, and racial/ethnic disparities in Health care access...

Access: Minorities are less likely than non-minorities to have access to regular medical care and to have health insurance

Low income Americans runs the highest risk of being uninsured. In 2003, 45 million people lacked health insurance, and the numbers have increased since. Among minority groups, Hispanics are the least likely to have health insurance (32.7% uninsured), followed by American Indians and Alaska Natives (22.7% uninsured) based on a 2-year average (2002-2003). Compare this to 19.6% of Blacks, 18.8% of Asians and Pacific Islanders, and 11.1% of white non-Hispanics who lack health insurance...

Treatment: Minorities are more likely to receive inappropriate or insufficient care than non-minorities

HIV infection is now the leading cause of death among African Americans between the ages of 25 and 44 and the second leading cause of death among

Latinos in this age group. The most telling data regarding adequacy of treatment for minorities come from the HIV Cost and Services Utilization Study that looked at the use of triple drug antiretroviral therapy, a treatment regimen that is very effective in delaying disability and prolonging the life of persons with HIV. African Americans were more than twice as likely as whites to not receive combination drug therapy and 1.5 times more likely to not get preventive treatment for pneumocystic carinii pneumonia (a common, but preventable, infection in people with HIV) than whites. Latinos were 1.5 times more likely than whites to not get combination drug therapy.

HIV/AIDS infections among racial and ethnic minorities are an ongoing crisis. The disproportionate impact of HIV/AIDS has affected communities that already struggle with social and economic challenges such as poverty, substance abuse, homelessness, and unequal access to health care. Dr. Paul Denning, epidemiologist in the CDC's AIDS Surveillance Branch remarks:

Race and ethnicity are not risk factors but are markers for other factors that put people at increased risk such as lack of health insurance and limited access to care.

Care and management of racial and ethnic minorities infected by HIV/AIDS have been even more complicated by the unequal access and treatment due to health insurance status, lack of concordance between patient and provider, and satisfaction with health care. This places a huge impact and burden on treatment outcomes within the minority communities.

Under-participation in HIV/AIDS clinical trials by minorities has been less than satisfactory. The under-representation has ironically shown an over-representation in

HIV/AIDS epidemiology. The under-representation appears to be a result of provider bias in referring clinical trials, mistrust of clinical research, past poor experiences with the heath care system, and conspiracy theories and stigma associated with HIV/AIDS. The paucity of minority health care professionals and investigators in HIV/AIDS research has also affected minority participation in clinical research (Office of AIDS Research, National Institute of Health).

There must be a concerted effort at multiple levels to improve efforts in clinical trials; and in order for FBOs to meet program objectives, these barriers to treatment must be addressed and amended. The collaborative efforts of communities, providers, and researchers must improve in order to address participation issues and to reduce barriers. Prevention of HIV/AIDS remains essential because of the devastating affects we all face.

For minorities, discrimination, poverty, and inadequate health care, and education exist as the most critical barriers to effective prevention awareness, intervention, and treatment. In some African American communities, homophobia and the belief that HIV/AIDS is a gay white man's disease have contributed to both the spreading and the hiding of the disease. Some believe the disease or the epidemic cannot affect them. When HIV/AIDS does strike, it is associated with homosexuality, therefore the presence of the disease is denied (Intergroup Minority Project, AIDS Consortium). In Lynda Richardson's "Distrust Stalls AIDS Fight, History Makes Blacks Uneasy", the article expounds on the suspicions of some African Americans towards AIDS treatment by protease inhibitors. She states that their belief is that AIDS is a virus that was "hatched in a government lab in a plot to eliminate blacks" and those who take the drugs are guinea

pigs for the government. The suspicion is rooted from the Tuskegee syphilis study of 1932-1972.

In many Asian/Pacific Islander communities, HIV/AIDS still often remain undiscussed and hidden where many immigrants believe homosexuality brings shame on the family. There is also a high rate of allergic reactions to sulfa drugs in the Asian population. This brings about unwillingness to participate in Western medicines and interventions (National Minority AIDS Council, Washington, DC).

In the Hispanic community, the language isolation and culture can be a roadblock to medical care and education. Many Hispanics live in their own communities and remain connected to each other but isolated from the mainstream. For those who only speak Spanish, they often never receive HIV/AIDS prevention messages. It is also common among Hispanics that people are born with their own cross to bear. For some having HIV/AIDS, it is believed that it is the cross (Hispanic HIV/AIDS Education, American Red Cross).

Faith, health and community partnerships. The faith, health, and community movement that has spread across the nation can be viewed as growth of congregation/community-based programs, health ministries, and interfaith service organizations engaging in Health related services. Through these faith-based structures, faith groups and communities are receiving the benefits of health education, counseling, and a wide variety of support services to advance and promote health and wellness (CDC/ATSDR Forum, 1997). Partnerships with faith-based organizations include, yet extend beyond places of worship to community-based health and social services organizations, hospitals, and community foundations that are founded on a mission of

health and healing. For example, The Roundtable on Religion and Social Welfare Policy connects the relationships of FBOs through various means and affiliations:

- A congregation-based FBO is a house of worship that directly provides social services without doing so through a distinct and separate organization. A congregation may be a mosque, church, synagogue, or other religious institutional services offered by congregation FBOs. Public funding can be through contract or grant to social services. This is a relatively new development.
- A local religiously-affiliated nonprofit is a social service provider that has incorporated a nonprofit organization and is related to a religious community. These organizations may at the very least have religious roots in their origin or ideology, although the services they provide may or may not have explicit religious content. The affiliation may be local or regional in its geographical service area.
- Religiously affiliated nonprofit organizations also include groups that are among the largest providers of social services in the nation. Multi-state or national faith-based service organizations are usually secular in their programming. FBOs of this type tend to be older and have an established history of providing social services with governmental assistance (e.g., Catholic Charities, Jewish Family Services, Lutheran Social Services, Volunteers of America).
- Faith-based coalitions are composed of a number of organizations, some or all of which are faith-based. These coalitions are formed to address a deficit in a service area.

- Faith-based intermediaries are organizations that primarily serve to support the work of FBOs (technical assistance, training services, finances, administration).

Dr. Benjamin E. Mays cited at the CDC/ATSDR Forum that the aspiration was to have "all public health agencies involved with faith organizations in their community". He further expounded on the importance of the collaborative efforts needed to find common ground for the "effective resolution and prevention" of many of our most difficult social health concerns (e.g., teen pregnancy, violence, HIV/AIDS, sexually transmitted diseases, substance abuse).

Polarized battles involving special interests and high moral principles have long been the catalyst for the church and state debate. To many, the church and the government are both essential institutions in which people rely on for assistance. It gives a sense of power, meaning, and community bonding. The issue became a hot topic when President George Bush created the White House Office of Faith-Based and Community Initiatives in order to collaborate efforts between government and faith-based organizations. He also created centers for the initiative in ten Federal agencies: the Department of Justice, Agriculture, Labor, Health and Human Services, Housing and Urban Development, Education, Commerce, and Veteran Affairs, the Agency for International Development, and the Small Business Administration. The goal was to ambush a "determined attack of need" by strengthening and expanding the role of these groups in addressing the nation's huge social problems. Each center contributes to the resource network needed to fight the plight of HIV/AIDS. President Bush's goals and commitment resonates in his following comments:

"The indispensable and transforming work of faith-based and other charitable service groups must be encouraged. Government cannot be replaced by charities, but it can and should welcome them as partners. We must heed the growing consensus across America that successful government social programs work in fruitful partnership with community-serving and faith-based organizations. I believe in the power of faith in people's lives. Our government should not fear programs that exist because a church or synagogue or a mosque has decided to start one. We should not discriminate against programs based on faith in America. We should enable them to access Federal money because faith-based programs can change people's lives, and America will be better off for it."

In October 1998, President Bush declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities. In response, the Administration, the Department of Health and Human Services (DHHS), the Congressional Black Caucus (CBC), and the Congressional Hispanic Caucus (CHC) announced a special package of initiatives aimed at reducing the impact of HIV/AIDS on racial and ethnic minorities. The Minority HIV/AIDS Initiative is part of HHS' larger Initiative to Eliminate Racial and Ethnic Disparities in Health by the year 2010. The Minority HIV/AIDS Initiative provides funds to community-based organizations, faith communities, research institutions, minority-serving colleges and universities, health care organizations, state and local health departments, and correctional institutions to help them address the HIV/AIDS epidemic within the minority populations they serve. HHS is working through its agencies to provide grants for programs dealing with HIV/AIDS prevention

and education, research, faith-based initiatives, prison programs, expansion of treatment capacity, bilingual and bi-cultural services, and other special projects (Office of Minority Health Resource Center). The agencies are:

- Centers for Disease Control and Prevention provides leadership in the prevention and control of diseases and other preventable conditions that threaten the public health. The HIV program of the CDC has five major components. The components include: technical and assistance to state, local, and health education agencies, minority, regional, national, and community-based organizations for HIV/AIDS surveillance, research, prevention, intervention activities; national public information activities (e.g., hotlines, information clearinghouse, online treatment, referral sources, media campaigns, web pages and databases); activities that produce information regarding HIV/AIDS cases, transmission, related knowledge, attitudes, beliefs, and prevention and control of the disease in the U.S.; HIV prevention guidelines, recommendations, and training; and program evaluation.
- Substance Abuse and Mental Health Services Administration administers three centers that coordinate Federal programs related to substance abuse and mental health services: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). The agency's work is also coordinated in area of AIDS, women, minorities, policy, care, prevention, and treatment. SAMHSA supports research in understanding and assessing neurological, psychiatric, behavioral, and psychosocial aspects of HIV infection.

- National Institutes of Health is responsible for supporting and conduction biomedical research. The work includes development of candidate vaccines, drugs, and other treatments to prevent and control HIV infection. NIH also supports clinical trials that evaluate the effectiveness of specific drugs and treatments.
- Health Resources and Services Administration is responsible for the grant programs authorized by the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. HRSA's HIV/AIDS Bureau (HAB) coordinates the Federal AIDS programs relating to patient care, Health services delivery, data collection, and health professionals training.
- Office of Minority Health promotes improved health among racial and ethnic minority populations. It is responsible for coordinating minority health policy and programs linking Federal, State, and Local governments with community-based organizations that work with minority populations.
- Indian Health Services provides a comprehensive health service delivery system for American Indians and Alaskan Natives, which encourages maximum tribal involvement in developing, and managing programs to meet their health needs. The agency operated the HIV Center for Excellence (HIVCOE), which specializes in issues of HIV and STD prevention within their community.

Methodology

Overview: The study's objective was to determine the effectiveness of FBOs in the prevention of HIV/AIDS in minorities. Because few surveys were found that explored FBO participation in HIV/AIDS activities, programs, or collaborations and few

published studies have evaluated the health-service related work of FBOs, case studies from the Roundtable on Religion and Social Welfare Policy were used as references for models. The relevant material provided the scope and scale of faith-based social services and the extent of their delivery services. The analysis of relevant articles, journals, and research examined scope and scale of service, program's description, funding, successes, shortcomings, and reporting methods.

Based on the information gathered from the literature review, a qualitative and quantitative research design was formulated. Prevention programs that promote behavior and social changes have been recommended as effective tools for community prevention and control of HIV/AIDS (Health, U.S., 2004). Additional researchers' perspectives were used to gain a variety of perspectives on methods of effectiveness and accountability.

This study design assessed the impact that FBOs has on HIV/AIDS in minorities. Effectiveness was based on the FBOs involvement and role in public policy formation, client outcomes, U.S. HIV/AIDS declines, and effective social support ties. HIV/AIDS prevention behavior is affected by the environment as well as characteristics of individuals at risk. Structural factors defined as barriers to, or facilitators of an individual's prevention behaviors can be social, economic, policy oriented, organizational, or environmental. Very few intervention studies demonstrated the potential of structural interventions to increase HIV/AIDS prevention in the U.S. and internationally. However, the promise of structural interventions has been shown in studies of interventions to prevent and promote public health in areas other than HIV/AIDS. Frameworks help define and exemplify structural barriers and facilitators for

prevention. The CDC cites structural facilitators in terms of economic resources, policy supports, societal attitudes, organizational structures, and functions associated with governments, service organizations, faith communities, media organizations, businesses, educational systems, and health care systems (Lippincott, Williams, & Wilkes, 2004).

Two separate questionnaires were formulated in an attempt to help assess programs' roles, successes, or shortcomings from within the communities in which they served. Program coordinators and executive program directors were given the "Program Contact Questionnaire". Health professionals (e.g., physicians) were given the "Professional Contact Questionnaire" in order to obtain a more balanced perspective, but not a totally objective one, based on how FBOs served the needs of their clients within their communities.

Limitations of study: Time was of the essence, therefore posing a huge constraint on the overall study. The holiday seasons and other "end of year obligations and commitments" for program-contact participants posed a threat for the research study, specifically related to responses for the "Program Contact Questionnaire". This included initial phone contacts for participation requests, requests for phone interviews, and questionnaire responses. There was an even more practical challenge in obtaining sufficient relevant data that would support the depth of the research. Upon gathering sources for program contacts, several barriers and challenges occurred such as:

-Databases were not maintained and updated.

-Programs were no longer in existence.

-Program Executive Directors listed on the directory were no longer with the organization.

-Phone attempts for research participation and interviews were not returned.

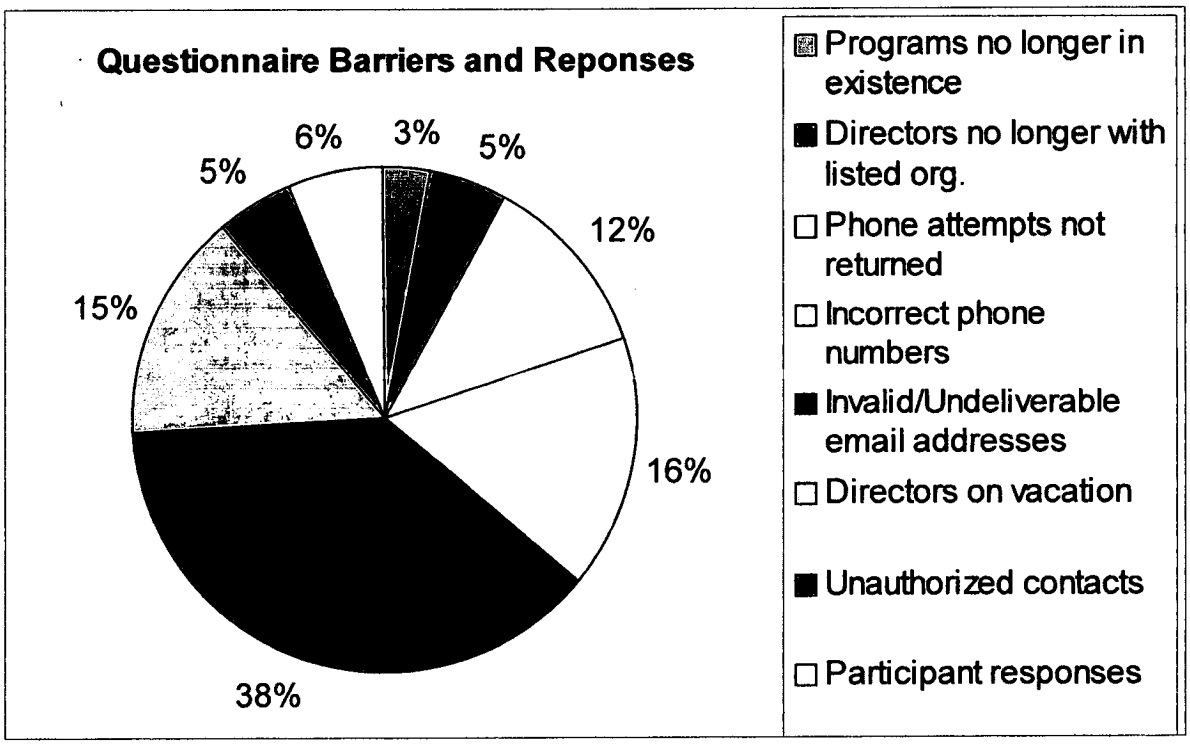
-Listed phone numbers were incorrect.

-Email addressees were invalid or undeliverable.

-Program Executive Directors and Coordinators who could help me with questionnaire responses would not be available until after Jan. 1, 2006.

-The contacts made did not have the authority to help me with the questionnaire responses because prior approvals from Executive Directors were needed. Program Directors were either out-of-town or on vacation for the remaining of the year.

-Follow-up responses were made on non-respondents during the entire process but were unsuccessful.

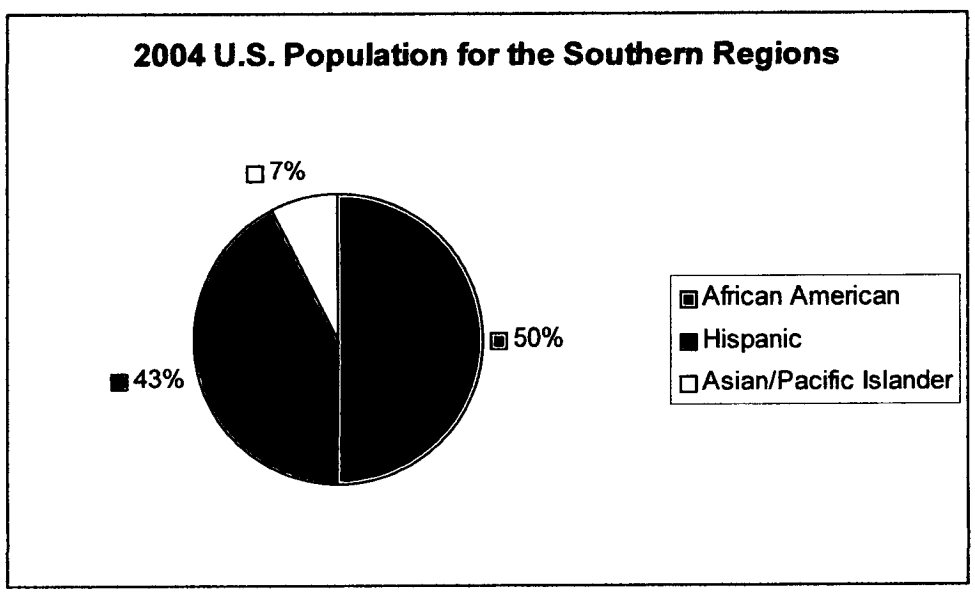


This process clearly indicated that reaching a high proportion of such organizations and obtaining cooperation so that valid data could be obtained was a challenge in its own right. This in itself sheds light to an even bigger picture. For smaller faith-based groups that lack established and centralized mechanisms for collecting, analyzing, updating, and maintaining databases, the need is essential. It is critical if the country's social needs are to be met by the help of FBO collaborations. Therefore, more emphasis was placed on the relevant literature and the responses that were obtained from participants. While the literature review and questionnaire responses supported the increasing use of FBOs to support societal needs, sufficient data did not support evidence of whether or how effective FBOs were. Participants who had used FBO services would have added objectivity and more depth to the research study. Because of confidentiality and anonymity name-based reporting in most states, time was a factor in locating willing subjects for participation. Ideally a combination of participant's perspective, programs' assessments, and health professionals' perspectives would have made for a more rounded analysis on FBO's true role, commitment, and value to the communities.

Research sample: The research sample consisted of FBOs and CBOs that provided activities, programs of awareness, or intermediary activities to help mitigate the impact of the HIV/AIDS epidemic. Sources for programs and contacts were from the CDC National Prevention Information Network, AIDS Survival Project, League Against AIDS, and Roundtable on Religion & Social Welfare Policy-Faith-based Social Services Southern Region, The Balm of Gilead-The Black Church HIV/AIDS Network, and the Directory of AIDS Ministries in the U.S.

The research sample also included responses from two Infectious Disease Physicians/Professors who work closely with HIV/AIDS patients and refers FBO services to these patients. Another response was from a Family Medicine physician who has used extended HIV/AIDS services by networking through churches.

The target population included FBOs that targeted services to African Americans, Hispanics, and Asian/Pacific Islanders. HIV/AIDS demographics were selected by distribution of race and ethnicity and poverty rates by race and ethnicity. Based on cumulative HIV/AIDS and new HIV/AIDS cases by race and ethnicity, the southern region was selected. The region included the following states: Texas, Florida, N. Carolina, Georgia, Virginia, Maryland, Tennessee, Oklahoma, Louisiana, S. Carolina, Arkansas, Kentucky, Mississippi, Delaware, District of Columbia, Alabama, and W. Virginia. Target groups were not categorized by nominal characteristics.



*Statistics by Kaiser Family State Health

Data collection: Two written questionnaires were developed to seek balanced perspectives from FBO program contacts and physicians who extend these services to

their clients. The "Program Contact Questionnaire" consisted of a personal introduction, introduction of research purpose, research specifications, and nine questions. The questionnaire requested participation permission, use of name, program identification, and assessment answers. Open-ended questions aimed to obtain information on program objectives, services, target groups, and years of existence. More specific questions were designed to assess programs' successes, how they measured and reported outcomes, and improvement needs (Appendix B).

The "Professional Contact Questionnaire" also consisted of a personal introduction, introduction of research purpose, and research specifications. The questionnaire requested participation, permission of use of name, program identification, and assessment answers. Open-ended questions sought to gain their perspective and professional experiences with FBOs within their communities. It was also designed to gain their perspective on whether medical and community liaisons were collaborating effectively in HIV/AIDS efforts, which helps in combating the epidemic through awareness campaigns, drug therapies, prevention, and intervention methods.

Respondents were given approximately six weeks, excluding holiday weeks, to respond to phone contacts and questionnaires. Seventy-five percent of the "Professional Contact Questionnaires" were returned. Less than six percent of "Program Contacts Questionnaires" were returned.

Summary of research process: The "Program Contact Questionnaire" contained nine questions. The first question asked for permission to use responses as part of my research process. A "yes' or "no" response was required. The second question requested permission to use programs' identification, contacts' names, and use of informants'

assessment as part of the research process. A "yes" or "no" response was required. Question 3 asked the informant to describe their title and contribution to their program. This question was answered only if prior permission was given in question two. Question 4 was designed to gain knowledge of the services provided by the program, scope of services, and years of existence. The scope and scale refers to the characteristics of FBOs and their activities. This helps to determine FBO's capabilities in providing services and if resources are adequate in helping to provide these services. Informants' scope of services mainly included HIV/AIDS education programs through confidential testing, drug therapy assistance, abstinence from sex, drugs, and alcohol, and case management programs. Programs had at least 10 or more years of experience in providing services to high-risk individuals and their sexual partners, and minorities. Questions 5 and 6 were designed to seek programs' successes, desired measurable outcomes, and how their outcomes were reported. This question examined the extent and nature of involvement in HIV/AIDS related activities, factors that influence such involvement, and its effectiveness. Each informant felt their programs were effective in combating HIV/AIDS. One informant based its effectiveness on the reduced HIV infections in the local gay community, which was down by 50% compared to previous statistics. Another informant based their program's effectiveness on the number of individuals tested since their 1992 establishment. Over 1200 individuals had been tested and approximately 5000 educated through their prevention and education teachings through group and street outreach settings. Informants did not provide a specific tool of measurement, indicators used, and reporting methods in assessing desired outcomes. One informant stated the number of people tested and the percentages of "positives" measured

outcomes. The other informant stated the number of new HIV/STD infections and the answers received from surveys and evaluations measured its program's outcomes. Another informant stated their program did not measure individual outcomes; and they only kept track of how many individuals used their services, along with the patient's demographic information. For long-term existence, with collaboration of NGOs and other partnerships, FBOs must be accountable for how they measure, validate, and report outcomes. Question 7 inquired if participants' lives were better as a result of their program. If so, what was the tangible evidence? Again, specific benefits tied to participants could not be reported. One response from an informant stated that participants gain knowledge from HIV/STD infections, which encourages them to make healthier choices about sex and feel that they are more in control of their lives. Another informant concluded that participants' lives are better because those that test negative are helped to develop a risk reduction plan; and those that are positive are linked to treatment, care, partner notification, and helped to develop a risk reduction plan to reduce the number of people they may infect. Little systematic knowledge exists concerning how FBOs influence risk and prevention strategies and responses to HIV/AIDS at individual, community, and societal levels. Even less is known regarding "faith" aspects and its influence. Empirically based evidence will contribute to understanding the factors that drive HIV/AIDS risk and also add to the development of innovative prevention and care strategies (DHHS, 2004). Questions 8 and 9 delved into the challenges, concerns, suggestions, and areas of improvement that would help FBOs' future stability and viability. This question was designed to expose gaps in human resources or funding that fail to meet the societal needs of the community. Having enough staff and money was

the biggest challenge faced according to FBO informants. One respondent stated competitions with other pharmaceutical companies who are better funded are a challenge. Another respondent felt that reaching African American and Hispanic populations were harder than reaching other community segments. This was not specific in what areas and to what degree (e.g., testing participation, educational methods used for abstinence from sex, drugs, alcohol, case management).

The "Professional Contact Questionnaire" contained eight questions. Questions 1 and 2 were exactly as those from the "Program Contact Questionnaire". The questions asked for permission to use responses as part of my research process, use of program identification, contact's name, and use of informant's assessment as part of my research process. These questions also required a "yes" or "no" answer. Question 3 asked for the health professional's name, background, and efforts as related to HIV/AIDS. This question was answered only if prior approval was given in question 2. This question would support health professionals' background, experience, and knowledge specific to the research study. Two physicians/professors specialized in Infectious Diseases, particularly AIDS patients, and works extensively in HIV prevention research. These physicians have had extensive experience in participating in community programs throughout the state of Georgia and other parts of the country. The other physician is a Family Medicine physician who works within local church communities addressing HIV/AIDS. Questions 4 and 5 inquired about specific FBOs they were experienced or worked closely with in combating HIV/AIDS in minorities. The physicians have worked with some of the following programs: Angels, St. Peter Claver Catholic Church, Beulaland Baptist Church, New Fellowship Baptist Church, St. Paul Episcopal Church,

Forest Hill Methodist Church, AIDS Community Wide Program at Mercer University School of Medicine, various vacation bible school classes, and church workshops. There were a total of 521 workshops, lectures, and seminars that Dr. Harold Katner had supported throughout his career. He also has participated in national and international media coverage's including the Sally Jesse Raphael Show. The main target populations served in these faith-based programs were African Americans, women, and youth (did not specify ethnicity). Questions 6 and 7 were designed to obtain the physicians perspective on whether these programs were effective in achieving the programs' desired outcomes and whether or not medical and community liaisons were effectively collaborating their efforts in the HIV/AIDS epidemic. This question aimed to help support or refute claims made by program informants. This opinion would be solely based on the physicians' experiences with FBOs in their communities. This is certainly not a true indicator for validation, but provides another perspective. There were three different perspectives on this set of questions. The first response believed that programs raise awareness of the problem but it was hard to judge outcomes on behavior change. The second response believed that programs were not evaluated enough to determine effectiveness. The third response had "mixed feelings". He stated it depends on the person and their situations but have good results with those dealing with substance abuse. Two physicians shared close opinions of whether medical and community liaisons were working together to effectively combat the epidemic. There is not successful collaboration on both sectors because outcomes are not specific for demonstrating direct impact and needs do not match efforts. A more positive response by the other physician found an overwhelming positive reception within the African American community and

states there is not enough time to accommodate all of the requests he receives. Question 8 provided an opportunity for suggestions, comments, or needed improvements. There was a consensus by the physicians that there is a need to develop more programs that "work", can be evaluated, and easily implemented in other areas. There was also the suggestion that outreach programs and education efforts should be taken to the "Projects" because most patients who became infected were not regular church attendees, since this is where most of the programs originate. There clearly must be a wider range of involvement from those with expertise in HIV/AIDS, those who study faith or religion, institutional organization, service delivery, behavior changes, and other areas to fully understand the dynamics of FBOs and what vital roles and differences they can make in our communities.

Because questionnaires employed open-ended questions, neither checklists nor rating scales were used. Questionnaire data was analyzed, the number of questionnaires summed, and percentages were assigned based on responses.

Findings

The methodology for this research employed a review of relevant literature and questionnaires. The Roundtable on Religion and Social Welfare Policy provided a basic foundation for health-related FBOs and were used as benchmarks. Case studies were reviewed for delivery of services, challenges of implementation of services, and scale and scope of services. Statistical data from Kaiser Family State Health, CDC, National Institute of Health, and the Office of Health Disparities provided data for ethnic/race reported HIV/AIDS cases for the U.S.

Two questionnaires were developed for faith-based program contacts/informants and health professionals/physicians to gain a broader spectrum of how FBOs function, their roles, impacts within their communities, and how the health professionals viewed faith-based services within the communities in which they served. The results were analyzed and interweaved among relevant literature to determine if FBOs were making effective progress in the prevention of HIV/AIDS in minorities.

What behavior change communication strategies have FBOs used to reduce the risk of HIV/AIDS transmission? The National AIDS Commission recommended that federal health educators learn and take into account the cultural differences of minorities in order to target prevention messages successfully. Dorothy Triplett, assistant director for Minority and Other Special Population, Division of HIV/AIDS, CDC, states the CDC is working with community gatekeepers to change risky behaviors. It has also set up initiatives with the Minority Health Professions Foundation, all African American medical schools, and is working with the University of Puerto Rico (Greeley, nd.). At the National Institutes of Health in Bethesda, Maryland which supports AIDS clinical trials, officials are extending their efforts to enroll minorities, which has historically been under-represented in trials and treatment studies. Minority enrollments in AIDS clinical trials rose from 17% of enrolled subjects in 1988 to 44% in 1994. Barriers to participation in clinical trials exist both on the individual and community level. Barriers include, but are not limited to:

-Language issues.

-Inaccessibility of the research site (e.g., lack of transportation, travel distance, inconvenient clinic hours).

-Family responsibilities.

-Inability of research site to coordinate other health care needs (e.g., psychiatric, dental, case management).

-Fear and distrust of health care, research, or government involvement.

-Lack of information.

-Lack of incentives for participation for the researcher and individual.

Barriers at the community level include:

-Lack of perceived involvement in all stages of planning and development of clinical research.

-Lack of relevance to women and minorities.

-Lack of target outreach efforts.

-Lack of funding.

-Cultural differences between researcher and target population.

Healthy People 2000 facilitated a goal for the elimination for all health disparities in the U.S. A comprehensive strategy was developed to help meet goals in research, education, policy changes, and community partnerships.

Community-based organizations (CBOs) and FBOs have the ability to influence the attitudes and behaviors of their communities and to develop and implement programs to meet the needs of the people. The U.S. Agency for International Development has developed a long history in working with CBOs and FBOs to promote modes to improve economic prospects. In one program response for the questionnaire, the Education/Prevention Program Manger coordinates on-going education and prevention programs in 23 Tennessee counties, coordinates efforts with two prevention specialists,

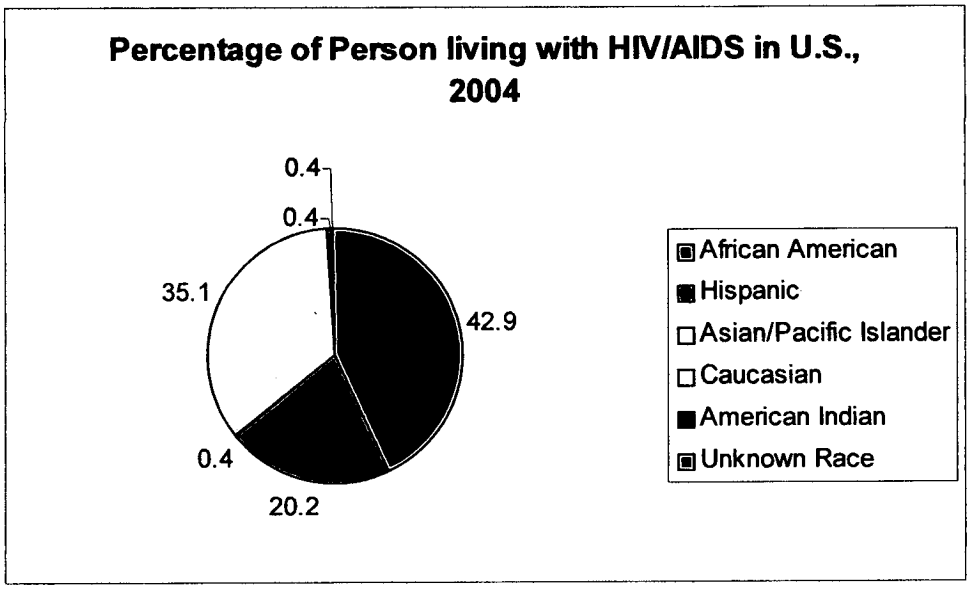
works with alcohol and drug addicted HIV/STD populations, and provides prevention case management to HIV positive individuals. The program teaches risk reduction methods to those who do not choose abstinence from sex, alcohol, or drugs. It was noted that participants have gained much knowledge on HIV and STD infections and this information has encouraged them to make healthier choices when it comes to sex. The program began in 1986 and the program's effort in combating HIV has resulted in the reduction of new infections in the local gay community. The numbers are down by 50% compared to the early 1990's numbers. In another program response, the Testing and Counseling Coordinator for in-house and mobile testing programs noted their program provided HIV prevention education through group and street outreach settings, confidential and anonymous HIV testing. The Testing and Counseling Coordinator noted that their communications strategies are linked to those that test negative are helped to develop a risk reduction plan. The clients who are tested positive are linked to treatment and care and encourage partner notification to help develop a risk reduction plan for future transmissions. This test site began in 1992 and has been mobile since 2001. From 2001, their program has tested over 1200 participants and educated approximately 5000 individuals annually. The communication strategies used by another program respondent who was the Treatment Education Program Manager, coordinated treatment forums. Their program used empowerment methods for those living with HIV to better help them understand the disease process and available treatments. It was noted that their participants feel more in control of their lives by the resources provided by their program. Their program's successful or effective efforts in combating HIV/AIDS included providing assistance to those on HIV medications. The respondent noted their efforts

consisted of sitting down and talking to individuals about their specific regimen and why it is important not to miss doses. "When people know why they need to take their meds on time, they are more likely to do so".

CDC's new initiative, Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic aims to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for HIV-positive persons and their partners. This is a multi-agency collaboration within the Department of Health and Human Services (DHHS). CDC then awarded five health departments and twenty CBOs for two demo projects which are: the Antiretroviral Treatment Access Study II and the Implementation of Rapid HIV Testing in Alternative Venues and Populations, Historically Black Colleges and Universities, and Primary Care Settings. The CDC has also realigned two large programs to support key strategies that improve delivery of services, early diagnosis, prevention, and evaluation methods. Continued efforts through AHP expand from publications, Internet sites, research, and federal partnerships to community and medical care communities.

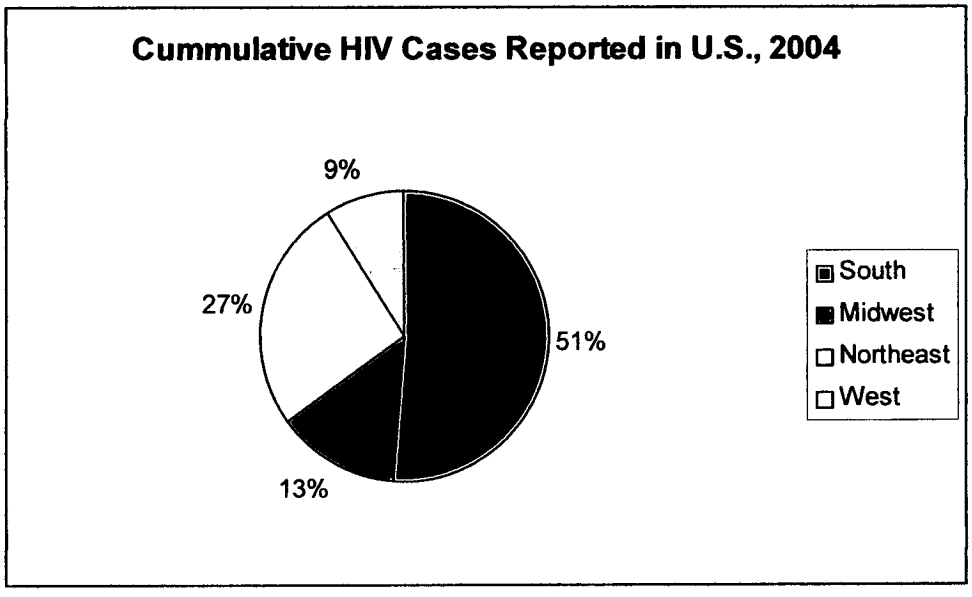
Even these initiatives continue to not have a substantial affect on the HIV/AIDS epidemic. HIV/AIDS continues to disproportionately affect minorities. African Americans and Hispanics constitute 58% of more than 928,188 cases of AIDS reported to the CDC since 1981. African Americans make up 50% of all AIDS cases, but only comprise 12% of the U.S. population, according to the U.S. Census Bureau. Hispanics represent 15% of all AIDS cases and comprise 13% of the U.S. population. The most recent data on Asian/Pacific Islanders state an estimated number of AIDS cases were 497 (Y2003) with a cumulative estimated number of AIDS cases of 7166. Their total U.S.

population comprises 12,696,704 (U.S. DHHS, 2005). These numbers are staggering when compared to the Caucasian population comprising 67% of the population with 376,834 reported AIDS cases.



*Statistics by CDC

CDC reports from 2000 through 2004, the estimated number of AIDS cases increased 25% in the South and 13% in the Midwest, and decreased 8% in the Northeast and 6% in the West, and 15% in the U.S. dependencies, possessions, and associated nations.



*Some states' data was not available due to non-implementation of confidential name based HIV reporting
Kaiser Family State Health Facts

What is FBO's involvement in helping to mitigate the impact of HIV/AIDS through the help of medical and community liaisons? The Department of Health and Human Services, Congressional Black Caucus, and Congressional Hispanic Caucus announced a special package to reduce the impact of HIV/AIDS on racial and ethnic minorities. The Minority HIV/AIDS Initiative is part of HHS' larger Initiative to Eliminate Racial and Ethnic Disparities in Health by 2010. Centers for the Initiative include:

-Department of Justice

-Agriculture

-Labor

-Health and Human Services

-Housing and Urban Development

-Education

-Commerce

-Veteran Affairs

-Agency for International Development

-Small Business Administration

Closing the Gap provides an important source of information and education on the health of African American, Hispanics/Latinos, American Indians, Alaska Natives, Asian Americans, and Pacific Islanders. *HIV Impact* is also a newsletter whose key efforts are to share information with those affected, involved, or interested in HIV/AIDS prevention, service, and research. The overall funding for AIDS-related programs with HHS has increased by 131% over the last six years, with funding for AIDS care under the Ryan White CARE Act while increasing by 314%. The FY2000 budget included $8.5B in total HIV/AIDS finding within HHS. With the support of the Congressional Black Caucus (CBC), $245M was secured to fund President Clinton's initiative to improve the nation's effectiveness in preventing and treating HIV/AIDS in minority communities (NIH, 2000).

Since 1988, John Hopkins Center for Immunization Research (CIR) has been involved in a search for a vaccine that prevents new HIV infections. With NIH funding, CIR has set out to build and create community partnerships through education and outreach campaigns (HIV Impact, 2000).

"Collaboration key to faith-based mission"

United Ways' Executive Director, Gordon Thibedeau, is enthusiastic about FBOs providing important services. Evidence of effectiveness can be found in local programs such as efforts to establish a homeless shelter. These efforts

have been ongoing by United Way agencies, local congregations, city, and county efforts. Government, nonprofit, and FBOs to provide monies for those who are in danger of being displaced established a rent-assistance program. These services are all axillaries for those with societal needs (e.g., HIV persons, those affected by violence, poverty).

Religious leaders are beginning to address the HIV/AIDS epidemic within the African American community directly from the pulpit. The Balm in Gilead has had twelve years of the Black Church Week of Prayer for the Healing of AIDS, which is a week of education and AIDS awareness that highlights the role of churches in addressing the AIDS crisis. Through funding from the CDC and Prevention and more than 615 AIDS service organizations and health departments, the Balm in Gilead remains a leader and model in addressing HIV/AIDS in faith-based settings (HIV Impact, 2002).

EVS Communications is an organization dedicated to improving the quality of life for Hispanic/Latino families through effective Spanish-language public education campaigns. The awareness campaigns are conducted in collaboration with bilingual social service agencies, foundations, National Latino organizations, and the Federal government. Through these campaigns, HIV/AIDS issues are tackled (HIV Impact, 2002).

Despite nationwide progress in reducing HIV infection and AIDS prevention, rates of HIV infection have remained constant in the Asian/Pacific Islander communities. While the number of reported AIDS cases among Asian/Pacific Islanders remain small, under-reporting and a lack of detailed HIV surveillance may minimize the true impact of the AIDS epidemic on the communities. The Asian/Pacific Islander Wellness Center is a

comprehensive HIV/AIDS services organization that targets Asian/Pacific Islander communities in the U.S. The center includes the Asian AIDS Project and the Living Well Project. In addition to treatment and care, the center specifically focuses on HIV/AIDS prevention through several different efforts including community organizations and outreach, workshops, support groups, peer counseling, and prevention case management (HIV Impact, 2003).

There were mixed feelings by the physicians that participated in the questionnaire as to whether or not medical and community efforts were effectively collaborating in combating HIV/AIDS. One Infectious Disease Physician and Professor noted that the collaborative efforts have been effective. "Being a white male, I have been overwhelmed by the positive reception I have received in the local African American community. I truly do not have time to do all of the programs I am asked to do". He also noted that these faith-based programs do raise awareness of the HIV/AIDS problem, but it has been difficult to judge outcomes based on behavioral changes. The other respondents either deemed the collaborative efforts as unsuccessful or had mixed feelings. The Family Medicine physician noted the collaborative efforts were not successful because evaluation of "outcomes were not specific for demonstrating direct impact". The other Infectious Disease physician and Professor had mixed feelings, but did note that good results had been seen in the substance abuse area. He also noted that Effective Champions (e.g., Magic Johnson) was a good program that served the needs of "young men of color". Two physicians did note outreach programs and educational efforts should be extended to other high-risk areas where there is not regular church attendance because most of the programs they have worked closely with are affiliated with the

church. It was also noted that there was a need to develop collaborative programs that "work" and can be evaluated and easily implemented in other areas. Based on the assessments, it appears that faith-based programs are facilitating efforts through education, treatment, and case management efforts for those affected with HIV/AIDS, but there must be a more concerted effort between the medical community and faith-based programs to better serve the needs to the people. However, there appears to be an ongoing commitment by government officials to support FBO and CBO collaborations with medical and community partnerships to help mitigate the impact of HIV/AIDS.

Can FBOs provide predictable and measurable health benefits in the communities in which they serve? "Health Programs in FBOs: Are they Effective?" study described the features of successful health promotion programs and partnerships in churches and the importance of the church as an ally in efforts to provide preventive health and social services to at-risk populations. The research focused on primary prevention, general health maintenance, cardiovascular health, or cancer. This study did not examine specific HIV/AIDS related FBOs. The first conclusion offered relatively little information exists, on which to base assessments of the effectiveness of such programs. The data concluded that FBOs could produce positive effects such as significantly increasing knowledge of disease, improving screening behavior and readiness to change, and reduce the risk associated with the disease and its symptoms (DeHaven et al., 2004). The conclusion was possibly drawn because of the accessibility and availability attached to the measured diseases. HIV/AIDS information is not readily available because of confidentiality and anonymity name-based reporting by states and also because of the stigma attached to the disease.

In Charves and Tsitsos' research on "Congregations and Social Services: What They Do, How They Do It, and With Whom", a different conclusion is drawn. They confer that faith-based social services only come in contact with the needy people who are likely to participate in these type programs. These programs tend to support short-term emergency needs such as the need for food, clothing, and shelter. They contend that faith-based social services play an important role in many communities social service systems, but it is not one of providing "holistic or transformational services". In their research they do acknowledge there is some evidence that points to the possibility that collaborations with government and secular organizations may encourage longer-term activities and goals.

Program respondents believed their programs did provide health benefits within their communities such as increasing the number of people tested for HIV, helping in the adherence to HIV medications, and by providing basic educational awareness through campaigns or teaching forums. Whether or not those health benefits were predictable and measurable is debatable. The professional respondents believed that predictable and measurable health benefits really were dependent on the person and his or her situation; and because most faith-based programs are not effectively evaluated, it's difficult to measure those benefits.

What is the perceived accountability of FBOs for criteria-based and empirical assessments for program effectiveness? Evidence for effectiveness in FBOs is sparse because there is no tool to measure faith and behavior outcomes. What are considered appropriate outcomes of success when the common denominator is faith? To develop FBO service models may involve the need to overlap FBOs and secular programs.

Program participants' spirituality can then be measured against a mechanism leading to success on other outcomes such as drug use, crime, or teen pregnancy.

Program respondents noted no specific guidelines used for criteria-based and empirical assessments for program effectiveness. There were no indicators of measurement or methods of reporting noted. Program respondents did note their programs' methods of measuring desired outcomes. These were the following responses:

"The number of people tested and the percentages of positive measure outcomes."

"We don't measure individual outcomes, we keep track of how many individuals access our services, along with demographic information".

"Outcomes are measured by the number of new HIV and STD infections and the answers we receive from evaluations and surveys".

FBOs are now encouraged to seek federal funding through the Compassionate Capital Fund in order to support faith-based delivery of services. This fund will help faith-based and community-based organizations increase their effectiveness and enhance their ability to provide social services to those in need.

Robert Fischer's assessment on alternatives offers viable avenues in improving FBOs and monitoring methods. He suggests the use of outcome measurement techniques such as those used by United Way funded programs. Outcome measurements are an evaluative approach that involves the use of program logic models in which tangible outcomes are identified and the implementation of systematic data collection and reporting procedures. The data generated from outcome measurements are useful for monitoring program effectiveness and program involvement (Fisher, R., 2004). Despite the increasing number of FBOs and funding of services, research is very limited and

under-developed. The U.S. General Accounting Office (GAO) (2002b) reported that the literature review provides on information on methods to assess the effectiveness of FBOs as providers of services. "Objective Hope" presents a systematic review of approximately 800 studies of the effectiveness of FBO services but concluded the overall body of work shows general favorable findings have not been the subject of serious evaluation research (Johnson, Tompkins, & Webb, 2002). There is a critical need to begin a broader movement of systematically collecting measurable outcomes on FBO services (Ragan, Montiel, & Wright, 2003). FBO research will within a broader context, help achieve more reasonable expectations among stakeholders.

A recent study by the GAO (2002b) found that in five states listed by auditors, officials reported holding FBOs accountable for performance in the same ways as non-FBOs in the delivery of social services. GAO did find a lack of uniformity that resulted in a lack of comparative data for FBOs versus non-FBOs.

The available evidence suggests that many FBOs may need specific assistance to develop the capacity to collect, manage, and analyze data. FBO supporters often cite exceptionally high rates of success for programs, but closer examination of the accounts tend to reveal mere simple summary statistics based on in-house data compiled by religious organizations (Johnson, Tompkins, & Webb, 2002).

There must be an increased collaboration between FBOs, non-FBOs, and health professional for evaluating health activities and disseminating findings. By increasing collaborations, it could facilitate evaluation strategies into programs and disseminate results on a broader spectrum. There must be more emphasis placed on effectiveness studies instead of efficacy studies. Efficacy studies test the effects of interventions

regardless of applications, whereas effectiveness studies test interventions in a way that is practical in the real world (DeHaven et al., 2004).

Are FBOs making an effective impact and contribution to the formation of HIV/AIDS public policies? The Bush Administration has eliminated regulatory and policy barriers that have kept FBOs from partnering with the Federal government to help Americans in need. It has also worked to put in place regulations to ensure that FBOs are able to compete on equal footing for Federal funding within Constitutional guidelines, without impairing the religious character of such organizations and without diminishing the religious freedom of beneficiaries.

Based on program contact responses and review of programs' scale, scope of services, and activities, there was no significant evidence to show if there were notable contributions to the formation of HIV/AIDS public policies. However, it is worthy to note that these faith-based or community-based programs face many challenges of staff, supply and funding shortages. Some are also faced with the challenge of competing with pharmaceutical companies, who are better funded and have instituted their own educational programs. A respondent noted these programs "may not always match the patients' needs".

Conservative ideology and social conservative religious viewpoints will continue to have a heavy influence on how the administration and Congress responds to the HIV/AIDS epidemic. Three areas will likely be affected are Federal Appropriations for HIV/AIDS, reauthorization of the Ryan White CARE Act, and health care access, specifically Medicare. President Bush's budget requests have called for flat funding for domestic HIV/AIDS programs and funding for global AIDS programs, which are well

below needed levels. Congress has, however, adhered to passing the actual appropriations. With inflation and rising caseloads, there has been a cutback for domestic HIV/AIDS programs. The recently enacted Omnibus Appropriations Bill for FY2005 exemplifies this trend (The Body, Complete HIV/AIDS Resource, 2004).

The current authorization of the Ryan White CARE Act expired September 30, 2005. HIV/AIDS public policy advocates are working on reauthorizing the Act. Medicaid is the largest source of health coverage for HIV/AIDS persons. The proposal to block this grant would eliminate entitlement nature of the program in exchange of states receiving lump sums of Federal dollars. Experts expect President Bush to revive his Medicaid capped entitlement and block grant proposal. If proposals are enacted, the impact of many people living with HIV/AIDS will have a negative or possibly life-threatening affect.

FBO constituencies extend well beyond active practitioners and offer an important vehicle for heightening attention among policy-makers to issues that contribute to AIDS impact, vulnerability, and risk. The moral leadership of FBOs could help guard against the politicization that funding can bring and maintain the focus on alleviating the HIV/AIDS pandemic.

Conclusion

Very little evidence was found to support how effective or if FBOs were effective in specifically preventing HIV/AIDS in minorities. There was evidence that many programs are participating in efforts of awareness, clinical trials, intervention, prevention,

and case management. There are also several programs designed to meet the societal needs of those infected, but no tools of measurement to show if these programs are providing successful outcomes.

Interorganizational collaboration for community health improvement and faith-based health related improvements are known to be time consuming and labor-intensive for participants; and the evidence for success in meeting FBO needs or changing the way health systems perform is mixed. FBOs are a vital part of communities and the lives that depend on their services. The value of FBO participation is of essence because of commitments to social justice, influences in leadership, access to populations, and opportunities to extend services beyond local, state, and even regional areas. There is a HIV/AIDS pandemic and also a great deal of undone work. However, progress has been made but yet an abundance of room remains for improvements.

Areas for Further Research

More emphasis should be placed on empirically based evidence with accountability measures. More time should be devoted to building relationships with the racially and ethically diverse populations. A study revealed that most faith-based programs were directly targeted to the African American population. This is not surprising since it is believed that in the majority of these communities that the church is considered the most important social institution and is the key community linking agent linking African American communities to the wider society (National Medical Association, 1995). However, we must recognize there are significant needs in the Hispanic, Asian/Pacific Islander, Indian, and other minority communities.

Extensive support for access to information, training, human and financial resources are vital if the roles of FBOs are to be supported in its role. FBOs must develop programs to help eliminate traditional, cultural, and health disparities. HIV/AIDS is the greatest threat to human well-being and public health. Millions are infected and have died and millions more will be affected directly or indirectly by this global pandemic. The scale alone is not the only threat of the AIDS pandemic, but the rate of its duration is more of a threat. Long-term commitments are necessary to control this disease and global efforts are needed. Further research on faith-based programs is needed to validate their efforts with funding, whether it is volunteer, private, or Federal.

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Appendix B

Program Contact Questionnaire

My name is Edrina C. Grant. I am a student at Golden Gate University enrolled in the Masters of Executive Public Administration degree program. I would like to request a small amount of your time in assisting me with efforts to complete my final capstone project. There is a questionnaire below designed at obtaining some basic information regarding your program's activities. I understand the demands and time constraints of your busy schedule, so I thank you in advance for your assistance.

Edrina C. Grant
GGU Graduate Student

RESEARCH SPECIFICATIONS: The study will examine the effectiveness of faith-based organizations (FBOs) for the prevention of HIV/AIDS in minorities.

1. Minorities: African Americans, Hispanics, Asian/Pacific Islanders.

2. Effectiveness of FBOs: Support activities or programs that support efforts aimed at HIV/AIDS prevention in the communities in which they serve.

3. Regions: The focus of the HIV/AIDS impact is on the Southern region, but is not limited to the respondents of this survey in this region. This could allow for a broader perspective of program functionality.

QUESTIONNAIRE:

1. Do you give me permission to use your responses as part of my research project?
___ yes
___ no

2. Do you give me permission to use your program identification, your name, and your contribution as part of the key informants' assessment?
___ yes
___ no

3. If you answered yes to question two, please describe your title and contribution to your specific program.

4. Please describe your program's objectives, services, target group, and years of program's existence.

5. Has your program been successful or effective in contributing to the efforts of combating HIV/AIDS? Please provide specific examples.

6. How are desired outcomes measured, what are the indicators, and how are they reported?

7. How are the lives of the participants better as a result of your program?

8. From your perspective, what challenges or concerns have you encountered with this program? Please describe.

9. Please provide additional suggestions or comments that would help to improve or enhance your program's future viability.

Appendix C

Professional Contact Questionnaire

My name is Edrina C. Grant. I am a student at Golden Gate University enrolled in the Masters of Executive Public Administration degree program. I would like to request a small amount of your time in assisting me with efforts to complete my final capstone project. There is a questionnaire below designed at obtaining some basic information on your perspective of how faith-based organizations make viable contributions to HIV/AIDS in our communities. I understand the demands and time constraints of your busy schedule, so I thank you in advance for your assistance.

Edrina C. Grant
GGU Graduate Student

RESEARCH SPECIFICATIONS: The study will examine the effectiveness of faith-based organizations (FBOs) for the prevention of HIV/AIDS in minorities.

1. Minorities: African Americans, Hispanics, Asian/Pacific Islanders.

2. Effectiveness of FBOs: Support activities or programs that support efforts aimed at HIV/AIDS prevention in the communities in which they serve.

3. Regions: The focus of the HIV/AIDS impact is on the Southern region, but is not limited to the respondents of this survey in this region. This could allow for a broader perspective of program functionality.

QUESTIONNAIRE:

1. Do you give me permission to use your responses as part of my research project?
___ yes
___ no

2. Do you give me permission to use your program identification, your name, and your contribution as part of the key informants' assessment?
___ yes
___ no

3. If you answered yes to question two, please describe your name, professional background, and your efforts related to HIV/AIDS?

4. What FBOs have you had experience or worked closely in combating HIV/AIDS in minorities?

5. Whom do the programs serve?

6. From your perspective, are the programs effective in achieving desired outcomes for the communities in which they serve?

7. From your perspective, are medical and community liaisons producing collaborative efforts in impacting and combating HIV/AIDS in minority communities? Please elaborate.

8. Please provide suggestions or additional comments on areas of improvements or changes needed to better serve the minority communities in combating the HIV/AIDS pandemic.